

Court of Appeals, State of Michigan

ORDER

ALAN THOMAS v MICHIGAN EMPLOYEE BENEFIT SERVICES

Docket No. 274084

LC No. 05-080689-CK

Jessica R. Cooper
Presiding Judge

William B. Murphy

Janet T. Neff
Judges

The Court orders that the May 22, 2007 Per Curiam opinion is hereby AMENDED. The opinion contained the following clerical error: the word "impatiant" shall be changed to "inpatient" on page 3, lines 13 and 26, and page 4, line 5, and page 5, lines 18 and 20.

In all other respects, the May 22, 2007 Per Curiam opinion remains unchanged.



A true copy entered and certified by Sandra Schultz Mengel, Chief Clerk, on

JUN 15 2007

Date

Sandra Schultz Mengel
Chief Clerk

STATE OF MICHIGAN
COURT OF APPEALS

ALAN THOMAS and CAROLYN THOMAS,

Plaintiffs-Appellees,

v

MICHIGAN EMPLOYEE BENEFIT SERVICES,

Defendant,

and

SWARTZ CREEK COMMUNITY SCHOOLS,

Defendant-Appellant.

UNPUBLISHED

May 22, 2007

No. 274084

Genesee Circuit Court

LC No. 05-080689-CK

Before: Cooper, P.J., and Murphy and Neff, JJ.

PER CURIAM.

Defendant Swartz Creek Community Schools (hereinafter “defendant”) appeals as of right from an order denying its motion for summary disposition, granting summary disposition in favor of plaintiffs pursuant to MCR 2.116(I)(2), and awarding plaintiffs \$34,663 in this action for recovery of supplemental health insurance benefits. We affirm. This appeal is being decided without oral argument pursuant to MCR 7.214(E).

Plaintiffs are teachers in the Swartz Creek Community Schools District and receive as an employment benefit for themselves and eligible dependents both medical insurance coverage under a plan with Blue Cross Blue Shield of Michigan (BCBSM) and supplemental coverage under a plan whose benefits and claims are administered by defendant Michigan Employee Benefit Services, Inc. (hereinafter “MEBS”).¹ Plaintiffs’ daughter, a dependent eligible for health coverage, suffered from anorexia nervosa and bulimia in 2003. Plaintiffs were unable to locate a facility in Michigan to treat their daughter’s diagnosed condition, so they admitted her

¹ Defendant is the actual “plan administrator.” Deposition testimony indicated that MEBS handled claims and distributed benefits and that MEBS would thereafter be paid by defendant to cover the benefits distributed by MEBS.

for inpatient treatment at the Renfrew Center in Pennsylvania in September and October 2003. Plaintiffs paid \$34,680 for their daughter's care. BCBSM paid only a few hundred dollars toward the costs,² and MEBS made a partial payment of \$4,627, allegedly only out of compassion, but defendant denied plaintiffs' request for full reimbursement. Plaintiffs thereafter brought this action for breach of contract, seeking recovery of the balance, approximately \$29,000, of the full cost of their daughter's care. Both defendants moved for summary disposition. The trial court granted MEBS's motion,³ but denied defendant's motion and determined that plaintiffs were entitled to judgment pursuant to MCR 2.116(I)(2). Defendant appeals.

This Court reviews a trial court's decision on a summary disposition motion de novo. *Spiek v Dep't of Transportation*, 456 Mich 331, 337; 572 NW2d 201 (1998). A motion under MCR 2.116(C)(10) tests the factual support for a claim, and summary disposition should be granted if, except as to the amount of damages, there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Babula v Robertson*, 212 Mich App 45, 48; 536 NW2d 834 (1995). "If it appears to the court that the opposing party, rather than the moving party, is entitled to judgment, the court may render judgment in favor of the opposing party." MCR 2.116(I)(2).

"[T]he interpretation of an insurance contract is a question of law that this Court similarly reviews de novo." *Allstate Ins Co v JJM*, 254 Mich App 418, 421; 657 NW2d 181 (2002). When interpreting an insurance contract, this Court reads it as a whole and accords its terms their plain and ordinary meaning. *State Farm Mut Automobile Ins Co v Descheemaeker*, 178 Mich App 729, 731; 444 NW2d 153 (1989). Courts will enforce an insurance contract as written if no ambiguity exists. *Farm Bureau Mut Ins Co v Nikkel*, 460 Mich 558, 566; 596 NW2d 915 (1999).

Here, the insurance policy, under "hospital benefits," covered one-hundred percent (100%) of inpatient hospital days relative to general conditions. There is also 100% coverage for such items as drugs, use of hospital equipment, laboratory and pathology, and diagnostic services relative to hospital stays. The policy defines "hospital," in part, as "[a]n institution for the treatment of mental diseases and disorders (exclusively), other than an institution the primary function of which is custodial and not therapeutic" The Renfrew Center appears to fit the definition. The "hospital benefits" section of the policy, referenced above, does not make any distinctions between in-state and out-of-state hospitals. However, under the policy's "outpatient mental health benefits" section, the following language is found:

² Initially, BCBSM greatly limited the benefits paid on the basis that the Renfrew Center was a non-participating hospital. Subsequently, BCBSM recognized that the Renfrew Center was a participating facility; however, it then determined that the Renfrew Center was a residential facility and not an acute care facility, thereby providing an alternate policy basis to keep the benefits paid at a minimum.

³ The trial court's dismissal of MEBS is not at issue in this appeal.

Out-of-State Inpatient Care: All out-of-state inpatient care requires Michigan Blue Cross pre-certification prior to admittance to a facility. For additional information regarding this provision, contact the Benefit Administrator, MEBS at 1-800-968-6327.

It is undisputed that plaintiffs did not request or obtain pre-certification from BCBSM. The documentary evidence established that plaintiffs contacted MEBS twice before their daughter was admitted, inquiring about coverage. Plaintiffs were simply told that the policy would not cover the treatment at the Renfrew Center, and the record does not show that MEBS shared any information regarding pre-certification.⁴ Initially, we find nothing in the summary plan description that precludes coverage in its entirety under the circumstances presented. Indeed, the “hospital benefits” section indicates that there would be coverage. While there might have existed some limits based on, for example, reasonable charges, the posture taken by defendant was that there was no coverage, period. The provision on out-of-state inpatient care does not provide that there is no coverage for such care; rather, it merely indicates that there must be “Michigan Blue Cross pre-certification prior to admittance.” Although plaintiffs were in contact with MEBS, they were not informed of any “pre-certification” procedure.

In defendant’s motion for summary disposition, it stated that “even had plaintiffs sought pre-certification, their claim for benefits would still have been denied because BCBSM does not cover out-of-state treatment at a non-acute inpatient care facility.” The problem with this statement is that plaintiffs were seeking recovery under defendant’s supplemental plan and not under their BCBSM plan. Indeed, defendant’s plan clearly provides that it offers coverage for items that may otherwise be excluded under the BCBSM plan. Our review of the summary plan description finds no exclusion for out-of-state treatment at non-acute inpatient care facilities.⁵ During the deposition of defendant’s assistant superintendent for personnel and business services, he continually relied on, in defense of defendant’s stance in this case, the provision regarding out-of-state inpatient care and pre-certification. Again, this provision does not

⁴ Plaintiff Carolyn Thomas testified that she was told that there was no coverage.

⁵ The guidelines for enforcing exclusionary clauses are summarized in *Century Surety Co v Charron*, 230 Mich App 79, 83; 583 NW2d 486 (1998):

Exclusionary clauses in insurance policies are strictly construed in favor of the insured. Coverage under a policy is lost if any exclusion in the policy applies to an insured’s particular claims. Clear and specific exclusions must be given effect because an insurance company cannot be liable for a risk it did not assume.

When reviewing an exclusionary clause, courts must also read the contract as a whole to effectuate the overall intent of the parties. *Pacific Employers Ins Co v Michigan Mut Ins Co*, 452 Mich 218, 224; 549 NW2d 872 (1996). If an insurer intends to exclude coverage under certain circumstances, it should clearly state those circumstances in the section of its policy entitled “exclusions.” *English v Blue Cross Blue Shield of Michigan*, 263 Mich App 449, 472; 688 NW2d 523 (2004); see also *Fragner v American Community Mut Ins Co*, 199 Mich App 537, 540; 502 NW2d 350 (1993).

preclude coverage, but appears to be more in the nature of a condition precedent. For defendant to complain that plaintiffs failed to satisfy the pre-certification provision is questionable, given that MEBS twice told plaintiffs that there simply was no coverage under the policy and given that MEBS did not mention pre-certification during plaintiffs' inquiries despite the policy language directing parties to contact MEBS about out-of-state inpatient care. Whether under principles of estoppel or waiver, we conclude that defendant was barred from arguing, after plaintiffs admitted their daughter to the Renfrew Center, that they failed to satisfy the pre-certification requirement. See *Kirschner v Process Design Assoc, Inc*, 459 Mich 587, 593-594; 592 NW2d 707 (1999). Although defendant would not have been barred from arguing that there was no coverage under the policy, consistent with what plaintiffs were told by MEBS, we find no exclusionary language in the summary plan description that would support a complete denial of benefits.

We note that, whether plaintiffs would have obtained pre-certification had they been correctly directed by MEBS and defendant when the pre-admittance inquiries were made is somewhat difficult to ascertain. "Pre-certification" is not defined in the policy. In the dictionary, "certification" is defined as the act of certifying, and "certify" means "to attest as certain; confirm: *He certified the truth of her claim.*" *Random House Webster's College Dictionary* (2001). Thus, it would appear that certification simply involved confirming that plaintiff's daughter was in need of treatment and would be going to the Renfrew Center and confirming that the Renfrew Center was a legitimate treatment facility. There are no disputes on these matters, and there was evidence that BCBSM considered the Renfrew Center as a participating facility under the BCBSM plan, indicating acceptance of the Renfrew Center as a legitimate treatment facility for mental health issues. Possibly, pre-certification would also entail confirmation that there was coverage under the policy. But, there is no exclusion in defendant's plan that would preclude plaintiffs from recovering the entire amount sought, and any exclusion in the BCBSM plan would be irrelevant. We do not read the "pre-certification" language as suggesting that certification was to be based on whether the BCBSM plan would cover the treatment under its language and exclusions. This would be an illogical construction of the term "pre-certification." As defendant itself concedes, this case is controlled by the language in the summary plan description (defendant's insurance policy).

Defendant's remaining issues on appeal need little discussion as they are greatly lacking in merit. Defendant argues that plaintiffs did not have a prescription or diagnosis for their daughter's treatment at the Renfrew Center as required by the policy, but it did not raise the applicability of this exclusion in its motion for summary disposition or supporting brief. Further, there is no evidence that defendant denied plaintiffs' request for benefits based on the lack of a prescription or diagnosis.

"[W]here a liability insurer notifies an insured of denial of coverage on a specific basis, the insurer may be estopped from alleging additional bases for noncoverage at a later time." *Weekley v Jameson*, 221 Mich App 34, 40; 561 NW2d 408 (1997). This rule will not apply, however, if it would create liability for the insurer contrary to the express provisions of the parties' contract because an insurer should not be held liable by waiver and estoppel to cover a loss for which it did not charge a premium. *Id.*

Defendant did not deny plaintiffs' request for coverage because of the absence of a doctor's diagnosis or prescription, but rather seeks to develop this argument for the first time on

appeal. Accordingly, we do not believe that defendant may now rely on this exclusion to deny coverage. Even if the merits of this argument are considered, however, plaintiffs have submitted evidence that both a doctor and a nutritionist referred them to the Renfrew Center for their daughter's treatment. Because defendant did not cite this reason earlier when denying coverage, plaintiffs were not obligated to come forward earlier with a diagnosis or prescription to support their claim. Given that plaintiffs have now demonstrated the necessary medical support for their daughter's treatment at the Renfrew Center, we reject defendant's belated attempt to rely on the prescription exclusion as a basis for excluding coverage.

Defendant also argues that the plan administrator retained the right to enforce its provisions and solely determine coverage and, therefore, it properly refused to pay this claim in full based on the exclusion for unreasonable charges. We disagree.

Defendant argues that, under the policy, the plan administrator retained the right to decide an unreasonable charge and exclude from coverage any amounts deemed unreasonable and the administrator could limit the amount of recovery relative to mental health services.

Reading the pertinent provisions in the summary plan description, the plain and unambiguous terms of the plan gave the administrator the right to reduce or reject a charge that was unreasonable, or to pay only a limited amount for medical-surgical benefits related to inpatient physician services for mental health conditions. But claims representing reasonable amounts customarily or usually charged were to be paid under the plan. Additionally, the section regarding "medical-surgical benefits" and inpatient physician services for mental health conditions only provides that the 100% payment may be on "limited amounts;" it does not state that there would be no recovery. Moreover, physician services represented only a portion of the billing.

There is no factual dispute that defendant declined to pay plaintiffs' claim because it believed that the amounts charged at the Renfrew Center were not representative of the typical or customary amounts charged for the same or similar services at other like facilities. Defendant presented no evidence or offer of proof that the cost of treatment for plaintiffs' daughter's care was outside the realm of what is deemed reasonable at comparable facilities. Furthermore, plaintiffs were told prior to the treatment that there was simply no coverage whatsoever for treatment at the Renfrew Center. Defendant is now apparently presenting any and all arguments that might conceivably support denial of coverage, but they fail because they are not supported by the policy's language, the facts of the case, the legal positions taken by defendant below, and the statements made by defendant and defendant's agents to plaintiffs throughout their course of dealings.

Affirmed.

/s/ Jessica R. Cooper
/s/ William B. Murphy
/s/ Janet T. Neff